Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 17, 2022
Inspection Number 2022_1337_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Kensington Health Centre

Long-Term Care Home and City
The Kensington Gardens, Toronto

Lead Inspector
Wing-Yee Sun (#708239)

Additional Inspector(s)
Julie Ann Hing (#649)

Inspector Digital Signature
Wing Yee Sun
2022.07.25 07:19:55 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 25, 26, 27, 28, 29, 2022, May 2, 3, and 4, 2022.

The following intake(s) were inspected:

- Intakes #008347-21, Critical Incident System (CIS) #2852-000015-21 and #021080-21 (CIS #2852-000028-21) related to plan of care.
- Intake #018369-21 (CIS #2852-000021-21) related to safe and secure home.
- Intakes #019186-21 (CIS #2852-000022-21) and #020054-21 (CIS #2852-000025-21) related to falls prevention and management.
- Intake #008145-22 (CIS #2852-000006-22) related to a communicable disease outbreak in the home.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that additional precautions and standards under the IPAC program were followed by staff.

Rationale and Summary

(i) A Laundry Aide was observed inside a resident room labelling the resident's clothing. According to the signage posted on the resident's door they were on droplet/contact precautions. The Laundry Aide was observed not wearing a gown as required per additional precautions.

(ii) A Registered Practical Nurse (RPN) was observed inside a resident room performing a clinical assessment. According to the signage posted on the resident's door they were on droplet/contact precautions. The RPN was observed not wearing a gown as required, while in close proximity of the resident.

Failure of staff to follow the posted precautions increased the risk of transmission of infection.

Sources: Observations in home area, and interviews with a Laundry Aide, RPN and other staff.

(iii) A Personal Care Attendant (PCA) was observed sitting beside another PCA and eating in the nursing station. The two staff were not physically distanced.

Public Health Ontario (PHO) Coronavirus (COVID-19): Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes indicated there should be no food or drink at the nursing station.

Failure of staff to follow PHO guidelines increased the risk of transmission of infection on the home area.

Sources: Observations in home area, PHO COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes – Published December 23, 2021, and interviews with a PCA, and other staff.
[649]

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that residents were assisted with hand hygiene prior to meal service.

Rationale and Summary

(iv) 13 residents were observed entering the dining room for lunch. Staff did not assist residents with performing hand hygiene. Nine residents were observed eating and drinking independently.

The home's policy titled "Dining Room Service" directed staff to assist residents with hand hygiene upon entering the dining room.

A PCA acknowledged they had not assisted residents with hand hygiene prior to the meal.

Failing to assist residents with hand hygiene increased the risk of transmission of infection.

Sources: Observation of lunch service, the home's policy titled "Dining Room Service" #M2-370 revised date of July 2018, and interviews with a PCA and other staff.
[708239]

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure signage at the entrance to residents' room or bed space indicating enhanced IPAC measures were in place for residents on Additional Precautions.

Rationale and Summary

(v) All residents in one home area were on droplet/contact precautions related to an outbreak. No droplet/contact precaution signage was observed on eight resident rooms including one resident room who was identified as infectious.

The home's policy titled "Precautions - Droplet" indicated that registered staff will post signage on the resident's door indicating their precaution type.

Two RPNs were unsure why some residents who tested positive for a communicable disease had no signage on their room doors and residents who were asymptomatic had signage on their room doors. A PCA indicated they thought that the droplet/contact precaution signage were for residents who had tested positive.

Failing to ensure additional precautions signage was posted at the entrance to the residents' rooms increased the risk of transmission of infection.

Sources: Observations of home area, the home's outbreak line list, the home's policy titled "Precautions – Droplet" #M6-370 revised date of May 2014, and interviews with PCA, RPNs and other staff.
[708239]

WRITTEN NOTIFICATION ADMINISTRATION OF DRUGS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 79/10, s. 131 (2)

The licensee has failed to ensure that pain medication was administered to a resident in accordance with the directions specified by the prescriber.

Rationale and Summary

The resident was assessed as having moderate pain after a fall. The resident had as needed (PRN) order for pain medication. No pain medication was administered when the resident had pain post-fall, and there was no documentation of the resident's refusal of pain medication.

A RPN acknowledged that pain medication should have been administered to the resident as prescribed when they were assessed as having pain.

Failure of staff to administer PRN pain medication to the resident as prescribed put them at risk of not having their pain controlled.

Sources: Resident's November Electronic Medication Administration Record (e-MAR), post-fall assessment, weight and vital tab of pain assessment score, CIS repot, interviews with a RPN and other staff.
[649]

WRITTEN NOTIFICATION PLAN OF CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (9).

The licensee has failed to ensure that the provision of care set out in a resident's plan of care for the use of a fall prevention intervention was documented.

Rationale and Summary

The resident's written plan of care instructed staff to always apply a fall prevention intervention. The resident sustained a fall, and according to a post fall note they were not using their fall prevention intervention at the time of the fall. The resident sustained an injury as a result of the fall. The application of the resident's fall prevention intervention was initiated after the fall incident in Point of Care (POC), therefore PCAs would not have been aware of the intervention.

Failure of staff to initiate the task in POC for the application of the resident's fall prevention intervention led to the provision of care not being documented.

Sources: The resident's written plan of care, progress notes, POC documentation report, CIS report, interviews with a RPN and other staff.
[649]

COMPLIANCE ORDER CO#001 PLAN OF CARE

NC#004 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 6 (7).

The licensee shall:

(a) Conduct random audits of compliance with use of the fall prevention interventions for the two residents for a period of three weeks following the service of this order.
(b) Maintain a record of the audits, including the date, who conducted the audit, staff audited, results of each audit and actions taken in response to the audit findings.

Grounds

Non-compliance with: FLTCA, 2021, s. 6 (7).

The licensee has failed to ensure that the care set out in two residents' plan of care for the use of their fall prevention intervention were provided to the residents as specified in the plan.

Rationale and Summary

(i) The resident required a fall prevention intervention. Observation revealed that the resident was not using their fall prevention intervention when they were up in their mobility device in their room. A PCA told the inspector that they had been working with the resident for approximately one month and had not seen the fall prevention intervention used for the resident.

According to a PCA and RPN, the resident required the fall prevention intervention as they were at risk for falls due to poor sitting balance.

Staff failure to provide the resident's fall prevention intervention increased the risk of them losing their balance and falling.

Sources: Observation of the resident, review of resident's written plan of care, interviews with a PCA, RPN and other staff.
[649]

Rationale and Summary

(ii) The resident was at risk for falls and required a fall prevention intervention related to self-transfers.

The resident was observed in their mobility device without their fall prevention intervention. A Registered Nurse (RN) reported that the resident had a habit of standing up without calling for assistance.

Failure to ensure the resident's fall prevention intervention was applied increased the resident's risk of getting up and falling without staff being aware**.**

Sources: CIS report, the resident's written plan of care, observation of the resident, and interviews with a RN and other staff.
[708239]

This order must be complied with by July 28, 2022

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP#001

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NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order #001

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$1100.00,** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- Order #001 of 2019_769646_0018, LTCHA, 2007, s. 6 (7)

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch

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Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.